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ABSTRACT

A review was conducted of what the military services have done to determine the extent to which military physicians perform routine administrative and clerical tasks, and what the services have done to solve the problem. It was found that there is general agreement within the Department of Defense (DOD) and the military services that physicians are performing clerical and administrative tasks and that this detracts from clinical practice time and adversely affects physician productivity. Although the full extent of the administrative support problem and its effects are unknown, DOD health care professionals generally agree that it is a serious matter requiring priority attention. Each service has initiated or planned various actions to address the issue, but the impact of these actions may not be felt for a long time. The following topics are included: (1) background, objectives, scope and methodology of the review; (2) DOD and the services recognize the problem; (3) services' attempts to define the problem (Army, Navy, and Air Force); (4) DOD efforts to deal with the administrative support issue; and (5) conclusion. It is noted that providing adequate staff support could be a long-term project requiring multi-year budgetary commitments as well as monitoring to ensure effective implementation. (KM)

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United States General Accounting Office

GAO

Report to the Chairman, Committee on Government Operations, House of Representatives

February 1989

DOD HEALTH CARE

Extent to Which Military Physicians Perform Administrative Tasks

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General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-231236

February 13, 1989

The Honorable John Conyers, Jr.
Chairman, Committee on Government
Operations
House of Representatives

Dear Mr. Chairman:

This report is in response to former Chairman Brooks' request, dated April 27, 1988, that we review the extent to which military physicians perform routine administrative and clerical tasks. The request letter expressed a concern that these physicians were spending time performing office management tasks, such as answering phones and typing documents, that would be better spent providing medical care. These tasks are normally assigned to secretaries, typists, and clerks. As agreed with your office, our work was limited to examining what the military services have done to determine the extent of this problem and to solve it.

Results in Brief

Our work showed there is general agreement within the Department of Defense (DOD) and the military services that physicians are performing clerical and administrative tasks and that this detracts from clinical practice time and adversely affects physician productivity.

Although the full extent of the administrative support problem and its effects are unknown, DOD health care professionals generally agree that it is a serious matter requiring priority attention. Each service has initiated or planned various actions to address this issue, but the impact of these actions may not be felt for a long time.

Background, Objectives, Scope, and Methodology

The Military Health Care System is composed of the direct care systems of the Army, Navy, and Air Force as well as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).[1] The system provides medical care to the U.S. military forces, retirees, and their dependents. About 14,000 physicians, trained in various specialties, provide medical services, aided by a cadre of ancillary staff, including physician assistants, nurses, technicians, and administrative and clerical support personnel.

[1]CHAMPUS pays for a substantial portion of the medical care provided by civilian hospitals, physicians, and other civilian providers. Retirees and their dependents, active duty dependents, and dependents of deceased members obtain medical care from these providers when they cannot obtain it from military facilities.

We reviewed various DOD studies and documents that (1) addressed the subject of administrative and clerical support, (2) summarized physician opinions on administrative support issues, and (3) identified clerical shortages. We discussed these documents and studies and other matters related to administrative and clerical support with knowledgeable DOD and military service officials. In this connection, we interviewed medical, manpower, and policy officials in the Office of the Assistant Secretary of Defense (Health Affairs); the Army, Navy, and Air Force Offices of the Surgeon General; and the DOD Office of the Inspector General.

As agreed with your office, we did not survey the physicians directly, nor did we obtain official DOD comments on a draft of this report. However, we did discuss the results of our work with cognizant officials from each service and DOD. This work was performed between May 1988 and January 1989 in accordance with generally accepted government auditing standards.

Although GAO has never specifically reviewed administrative and clerical support for military physicians, the issue was noted twice in GAO reports on military medicine and physicians. In a 1979 report, we noted that physicians having to perform administrative tasks and the lack of support staff, such as secretaries, were cited as issues adversely affecting physician morale and efficiency.[2] We reported that physicians interviewed at seven military medical facilities complained about their administrative duties, such as locating and keeping track of medical records. In a July 1988 report, we reported that a shortage of medical resources was one of the most frequent comments by 550 (of the 1,350 surveyed) physicians who provided additional comments to a survey questionnaire.[3] Twenty-six physicians stated that their ability to provide health care was adversely affected by the lack of support personnel, and 38 cited old, outdated, or unavailable equipment as a problem hampering both the quality and efficiency of care provided.

DOD and the Services Recognize the Problem

DOD and military service officials acknowledged that physicians perform administrative and clerical tasks. Moreover, these officials stated that physicians' productivity is adversely affected when they spend time on administrative and clerical tasks—such as typing, filing, answering the

[2]Military Medicine Is in Trouble: Complete Reassessment Needed (HRD-79-107, Aug. 16, 1979).

[3]DOD Health Care: Additional Efforts Needed to Verify Physicians' Qualifications (GAO/HRD-88-39, July 18, 1988).

telephone, retrieving medical records, completing lab slips, and performing reception duties—instead of caring for patients. However, none of these officials could quantify this problem. According to an official from DOD's Office of the Assistant Secretary of Defense (Health Affairs), quantifying the need for and adequacy of clerical support for physicians would be difficult and expensive due to the differences among the three services as to how these duties are defined and who is responsible for performing them.

In 1984, the Assistant Secretary of Defense (Health Affairs) conducted a worldwide DOD Physician Survey covering a number of topics, including practice patterns and quality of care. The survey was sent to 5,247 physicians, of whom 3,727 (71 percent) returned usable questionnaires. These physicians expressed a desire for fewer administrative burdens and for less time devoted to nonmedical activities. Navy physicians reported spending the most time on administrative activities. The study report cautioned that its results should not be generalized to the Military Health Care System as a whole because of study design limitations, such as the generally poor design of the questionnaire.

In October 1987, the Society of Medical Consultants to the Armed Forces, an advisory group to the military Surgeons General composed of physicians, including active reserve and retired military physicians, published a report, Military Graduate Education Under Stress: A White Paper. The report noted that physicians' productivity was adversely affected as they were being called upon to perform clerical duties because of a reduction in the number of ancillary and administrative support positions. Staff shortages involving both health professionals and ancillary staff existed throughout the Military Health Services System, the report added, and they were most acute in the field of registered nursing.

In September 1988, the Office of the Assistant Secretary of Defense (Health Affairs) sent a Health Professionals Special Pay Survey questionnaire to physicians, dentists, nurses, and other health professionals throughout DOD. The survey focused on the adequacy of compensation, support, and facilities for these personnel. Over 80 percent of the survey respondents were dissatisfied with both the clinical and clerical support of their practice. Significant dissatisfaction with clerical support was evident across all services and units, with the largest facilities expressing the most dissatisfaction. In addition, about 80 percent of the respondents indicated that having adequate support staff was as important to them as compensation.

Services' Attempts to Define the Problem

Each of the three military services has taken some action to determine the extent and impact of the administrative and clerical staff support problem. These actions have included interviewing physicians and developing and distributing questionnaires and surveys to physicians. Though providing evidence that a problem exists, none of the efforts has fully quantified the extent to which physicians perform administrative and clerical duties.

Army

The Army recognizes that serious administrative and clerical support staff problems exist at its medical treatment facilities. However, it has not conducted a study to determine the extent to which physicians are performing administrative and clerical tasks at the expense of clinical practice time.

In 1986, the Army initiated the Army Medical Enhancement Program to increase staffing levels at medical facilities. One initiative of this program was to obtain contract civilian workers to rectify the critical shortage of nurses, technicians, and administrative support personnel. This program was designed to add 1,253 ancillary support staff, including administrative and clerical staff, to Army medical treatment facilities during fiscal years 1986 to 1989. Office of Surgeon General officials advised us that the goal of hiring 300 support staff in fiscal years 1986 and 1987 was achieved. However, because of budgetary pressures, no staff were hired in fiscal year 1988, and none or few will be hired in fiscal year 1989.

Another action initiated by the Army offers some potential to improve administrative and clerical support. The Army plans to reallocate 744 civilian positions, many of which are administrative and clerical positions, from nonmedical to medical areas during fiscal years 1990 and 1991. These positions will be filled at numerous Army installations.

Navy

According to the Navy Surgeon General's Office, physicians have a decreasing opportunity to practice medicine in a sound professional environment. It cites a decline in adequate medical treatment facility administrative and clerical support as an important contributing factor.

Three major events affecting medical administrative and clerical support in the Navy have occurred in the last two years. First, in 1987 the Navy added 411 civilian clerical support positions to increase beneficiaries' access to medical treatment facilities, reduce the time physicians

spend on administrative tasks, increase efficiency, and alleviate some of the top job dissatisfaction issues for medical corps officers. Second, the Congress appropriated $15 million for fiscal year 1989 to pay civilian employees to perform duties in support of Navy medical treatment facilities. Third, in May 1988, the Vice Chief of Naval Operations appointed a Blue Ribbon Panel to investigate problems and develop solutions regarding the Navy's health care delivery system.

In July 1988, a task force of the Blue Ribbon Panel was assigned to respond to the concern that too little emphasis was being placed on administrative and clerical support staff shortages in Navy medical treatment facilities. The task force was asked to quantify the problem in terms of objective requirements so it could be solved.

In December 1988, the Blue Ribbon Panel reported that 685 additional clerical positions were needed for the 24 Navy hospitals in the continental United States and recommended that these positions be filled over a 3-1/2-year period beginning in fiscal year 1989. Blue Ribbon Panel officials advised us that most of the personnel initially hired under this commitment will be deployed to the larger teaching hospitals, which have (1) the most physician specialists offering high potential to serve larger numbers of patients and (2) the highest potential for increasing the capability to handle more patients instead of having to send patients to nonmilitary hospitals and clinics under CHAMPUS.

Air Force

In May 1987, the Air Force Office of the Surgeon General asked the 12 Air Force major commands for their input on factors affecting physician career decisions and job satisfaction. The Surgeon General's Office gave each major command a list of 18 commonly perceived career irritants/dissatisfiers and asked them to assign priorities to the issues based on responses from their physicians. The results showed that inadequate administrative and ancillary support was the fourth highest ranked issue affecting job satisfaction, ranking behind emergency room coverage, physician staff shortages, and inadequate pay.

In July 1988, the Air Force's Tactical Air Command issued a report on the results of a survey conducted in April and May 1988 to determine the major irritants physicians encounter in their current jobs and to identify factors most likely to affect retention in the Air Force Medical Service. Surveys were mailed to all 462 Tactical Air Command physicians, and responses were received from 252 (or 55 percent). Three-fourths of the respondents had fewer than 10 years in the service.

Responses showed differences between the physicians' initial career plans and their plans at the time of the survey. Initially, about 8 percent of the officers had definite plans to leave the service at the end of their period of obligation, and about 20 percent had definite plans to remain. At the time of this survey, however, about 28 percent had definite plans to leave the service at the end of their obligatory period, and 15 percent had definite plans to remain. Inadequate administrative support ranked 5th among the 22 reasons given for leaving the service, behind emergency room coverage, participation in exercises, on-call duties, and pay.

The second most significant job irritant cited by survey respondents was the lack of administrative support, which was cited by 64 percent. The physicians cited the lack of clerical staff to perform such tasks as completing lab slips and pulling medical charts as a major problem because this tends to decrease the number of patients they can see. Physicians also noted that the number of other ancillary support staff, such as technicians, was inadequate.

The questionnaire also asked the providers to comment on what would most improve their satisfaction with the work environment. In order, the respondents said:

1. Eliminate medical duties outside of specialty (emergency room coverage).

2. Increase staffing.

3. Increase administrative support.

4. Decrease administrative demands (including quality assurance requirements).

5. Increase clinic support.

6. Increase general support.

7. Increase pay.

8. Improve equipment support.

9. Improve workload standards.

10. Participate in in-house decision making.

Responding to the question "What would most improve the attractiveness of an Air Force career?" physicians listed as their third, fourth, and sixth most cited reasons reducing administrative demands, increasing staffing, and increasing general support.

The Air Force has taken no action to increase the number of administrative and clerical support staff at medical treatment facilities. However, the Office of the Surgeon General established a working group in August 1988 to provide recommendations on how to increase medical service officer retention. As of January 1989, the working group had not identified or recommended any specific initiatives to address the administrative and clerical support problem indicated by the two physician surveys. The group was still studying the matter and had not established milestones for completing its work.

DOD Efforts to Deal With Administrative Support Issue

In March 1987, the Assistant Secretary of Defense (Health Affairs) directed that standards be developed to ensure that the peacetime staffing requirements of the Military Health Care System provide quality care in a productive environment. The standards, when implemented, are to provide DOD and the military services a uniform system for determining peacetime health care manpower requirements for operating medical treatment facilities.

As of January 1989, the standards had been written, but not issued, for 47 of the 128 functional areas, such as surgery, urology, pathology, and pediatrics. Included as part of each standard is a list of the types and number of staff needed for hospitals and clinics of various sizes. For example, a pediatrics department of a nonteaching clinic with 408 to 549 clinic visits per year would require two staff—a pediatrician and a technician. The same type of clinic with 1,099 to 1,658 clinic visits per year would warrant six staff—two pediatricians, one pediatric nurse practitioner, one registered nurse, and two technicians. Not until such a clinic reached 1,659 pediatric visits per year would it receive any administrative or clerical support.

While fully supporting the concept of joint standards, officials of all three services expressed concern that the standards were developed too quickly, have not been validated, and do not address their specific needs and, therefore, need to be revised before implementation. The services provided written comments to DOD that included concerns about administrative support, which are summarized below.

The Army maintains that the standards underestimate, by several hundred, the administrative support requirements for its clinics. The Army maintains that the standards attempt to centralize certain activities that it does not think should be centralized.

The Navy commented that the standards provide no administrative support for smaller clinics and departments under the assumption that these units would be located near, and would be able to obtain all required administrative support from, larger departments. The Navy pointed out that the standards fail to recognize that each clinic will need at least a reception area and a telephone, both of which will require some personnel attention. Therefore, for example, the Navy recommends that there be at least one administrative support position for each clinic or department.

The Air Force provided comments on specific provisions for certain functional areas. For example, it pointed out that the standard for psychiatry fails to address positions for technicians and secretaries, and the standard for anesthesia fails to provide for recovery room clerical assistance.

In December 1988, a DOD official stated that each of the services still had concerns about the joint standards, especially about how much flexibility would be allowed in interpreting them. However, he believed about 30 of the standards would be completed and issued by the end of February 1989.

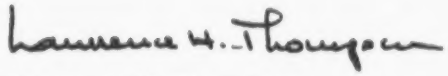
Conclusions

Shortages of administrative and clerical personnel are a problem that has concerned military physicians and affected their productivity for years. Although the magnitude of the problem has never been fully quantified, DOD health care professionals generally agree that it is a serious matter needing attention. Physicians maintain that they are much less productive than they could be because of the lack of staffing support, which decreases the level of services that can be provided in military treatment facilities. Providing adequate staff support could be a long-term project requiring multi-year budgetary commitments as well as monitoring to ensure effective implementation.

Unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will send copies to interested congressional committees and will also

make copies available to others upon request. This report was prepared under the direction of David P. Baine, Director, Federal Health Care Delivery Issues. Other major contributors are listed in appendix I.

Sincerely yours,



Lawrence H. Thompson
Assistant Comptroller General

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